NUCLEAR CARDIOLOGY PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: _______________

Referring MD: ____

Is this test for a pre-operative evaluation? YES or NO

If yes, what type of surgery? ______________________

Who is the Surgeon? ____

CLINICAL INFORMATION

Height: _________ Weight: __________ Age: _______ Breast cup size(female): _____

DO YOU HAVE:

Diabetes? YES or NO

High Blood Pressure? YES or NO

High Cholesterol? YES or NO HDL? YES or No LDL? YES or NO

History of Coronary Artery Disease? YES or NO

History of Asthma? YES or NO

Smoking history? __________________________ Quit, When? ___________________

Family history of heart disease? ___________________________________

HAVE YOU HAD:

Past heart attack? YES or NO If so, when? _______

Recent chest pain? YES or NO

History of Congestive Heart Failure? YES or NO

Past nuclear stress test? YES or NO If so, When? ____________ Where? __________

Past heart catheterization? YES or NO If so, When? ____________ Where? __________

Past angioplasty or stent? YES or NO If so, When? ___________ Where? _________

Bypass Surgery? YES or NO If so, When? ________________ Where? __________